Shared perceptions of ethics and interpreting in health care

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"Having two languages does not make you a translator or interpreter any more than having two hands makes you a pianist!!" (Trabing, 2007)

Abstract

The Code of Ethics for professional Interpreters and Translators practicing in Australia was developed by the Australian Institute for Interpreters and Translators (AUSIT) and endorsed by the National Accreditation Authority for Translators and Interpreters (NAATI) as well as accepted by most major organizations.

The issue of ethics is very important, especially today given the greater public scrutiny of services. The degree of trust that is placed on interpreters and the magnitude of their responsibility necessitate high, uniform ethical standards that will both guide and protect them in the course of their duties. It is critical that both interpreters and professionals alike have a clear and common understanding of the role and ethical guidelines of interpreters in order to avoid conflict and confusion.

The code of ethics is a management tool for establishing and articulating the values, responsibilities, obligations, and ethical ambitions of an organisation and the way it functions. It provides guidance to employees on how to handle situations, which may pose a dilemma between alternative right courses of action, or when faced with pressure to consider right and wrong. However, having a code of ethics is not enough. It can only be effective and practically useful with committed dissemination, implementation, monitoring and embedding at all levels so that behaviour is influenced.

This paper examines the beliefs held by practicing Health Care Interpreters, Health Professionals working with interpreters as well as non-English speaking and Deaf clients regarding knowledge of the code of ethics as well as implementation. It looks at the significance of ethical issues and what constitutes unethical or incompetent interpreting and how these can become a barrier to effective communication.

Résumé

Perceptions communes de déontologie pour l'interprétation dans le domaine de la santé

Le Code de Déontologie pour Interprètes et Traducteurs professionnels exerçant en Australie a été mis au point par l'Institut Australien des Interprètes et Traducteurs (AUSIT), approuvé par l'Organisme National d'Accréditation pour Traducteurs et Interprètes (NAATI) et adopté par la plupart des grandes organisations.

Le sujet de la déontologie revêt une grande importance, en particulier dans le contexte actuel où le secteur des services est soumis à un droit de regard accru de la part du public. Le degré de confiance accordé aux interprètes, et l'ampleur de leurs responsabilités, imposent l'application de critères éthiques rigoureux et uniformes qui les guideront et les protègeront dans l'exercice de leurs fonctions. Il est essentiel que les professionnels de la santé comme les interprètes aient une conception claire et commune du rôle et des règles déontologiques pour les guider afin d'éviter les conflits et les malentendus.

Cette étude examine les perceptions d'interprètes du domaine de la santé, de professionnels de la santé travaillant avec des interprètes, ainsi que de clients non anglophones ou sourds concernant leur connaissance du code de déontologie et son application. Elle considère l'importance des problèmes éthiques, envisage ce qui constitue un comportement contraire à

l’éthique ou incompétent de la part de l’interprète et examine comment ces comportements peuvent constituer un obstacle à une communication efficace.

1.0 Introduction

The issue of ethics is very important, especially today given the greater public scrutiny of services. The degree of trust that is placed on interpreters and the magnitude of their responsibility necessitate high, uniform ethical standards that will both guide and protect them in the course of their duties. As stated by Solow (1980:39) “A code of ethics protects the interpreter and lessens the arbitrariness of his or her decisions by providing guidelines and standards to follow”. It is critical therefore, that key stakeholders in the interpreting event have a clear and common understanding of the role of the interpreter juxtaposed with the interpreter’s Code of Ethics in order to avoid conflict and confusion (Diversity Rx, 2003).

In the discipline area of community interpreting research, numerous studies have explored the role of the interpreter, interpreter ethics and related principles (Hale, 2007), with sign language research being forerunners in the field (Mikkelson, 2000, 2001). Few however, have collected data on clients’ knowledge of interpreting practice. In the broader context of Auslan interpreting, Napier (2005) explored consumer perceptions and Napier (2006) looked at deaf and practitioner reflections. In relation to health care interpreting, much of the focus of research has been on interpreted doctor-patient interaction (Candlin and Candlin, 2003, cited in Hale, 2007). Language services in Victoria’s Health System however, recently commissioned a paper on consumer views on the effectiveness of language service provision in health settings (Brough, 2006). As far as the authors of this paper are aware, no research has been presented on participants, specifically, perceptions of interpreting and ethics of the health care interpreter.

The underlying premise for this study was to provide the Hunter New England Health (HNEH), Health Care Interpreter Service (HCIS) with a general overview of beliefs held by practicing interpreters, health professionals working with interpreters and non-English speaking

background (NESB) and deaf clients regarding knowledge and implementation of the profession's Code of Ethics. This paper will not explore whether the code needs to change (Cokely, 2000), instead it will focus on key stakeholders' knowledge of the role of the health care interpreter and the professions Code of Ethics, specifically what aspects of the code they were aware of and what they believed constitutes unethical behaviour and incompetent interpreting. Information elicited from the questionnaire will be categorized into AUSIT's ethical principles, which will illustrate how a breach of these principles can become a barrier to effective communication. To conclude, the paper will look at the responsibilities of the HCIS, by referring to the organization's policies and procedure documentation and make future recommendations.

2.0 Professionalism and Ethics

Despite interpreting being "one of the oldest of human activities" (Gentile, Ozolins & Vasilakakos, 1996: 5), interpreters in Australia have been seeking professional recognition for decades (NAATI, 2000).

The most likely explanation for this phenomenon relates to interpreting being carried out by migrants prior to the 1970's as an unskilled occupation. A resultant factor was the general perception that 'bilingualism was the only skill required to interpret'. Analysis of the quote that prefaces this paper illustrates the superficiality of this notion, suggesting that you need much more than the basic requirement. Accordingly, the following quote is one definition of liaison interpreting that supports this notion:

> "Liaison interpreting is a profession where, like medicine, teaching and the law, the client's welfare is usually affected directly. This is not only because most liaison interpreting takes place in the context of other professions such as medicine, teaching and

the law, but also because interpreting has its own knowledge, skills and practices which require particular ethical situations".

(Gentile et al., 1996:57).

Furthermore, as stated by Hale (2007), research conducted into interpreted doctor-patient interaction also supports the bilingualism misnomer (Kaufert & Putsch, 1997; Cambridge, 1999; Davidson, 2000; Bot, 2003; Meyer et al., 2003; and Angelelli 2004).

Ultimately this view was questioned in the early 1970's when issues around quality became a major concern. This led to the establishment of a National Accreditation Authority for Translators and Interpreters (NAATI), an organization with the objective of setting and maintaining high national standards, primarily through an accreditation process and more recently a re-validation of accreditation. Both these measures test the level of a person's competency, the latter introduced as an assurance of continuous practice and professional development. In addition to language testing, the accreditation process includes a component on ethical and socio-cultural aspects. As Tseng (1992) points out, the distinction between an occupation and a profession is a code of conduct (cited in Mikkelson, 2000/2001).Undoubtedly, the inception of NAATI and its incorporation of AUSIT's Code of Ethics saw the beginning of the professionalization of interpreting in Australia, thus supporting the notion that "professionalism and ethics are inextricably linked" (Gentile et al, 1996:56).

In essence, professional ethics provide a set of principles or rules that inform the behaviour of health care professionals resulting in the notions of predictability and reliability. Consistent with general practitioners, nursing practitioners and allied health professionals, interpreters have professional and ethical obligations. Furthermore, when integrated into practice, it ultimately defines their status within their respective communities. Special attention

needs to be given to issues of confidentiality, trust and clear demarcation between professional and social relationships. Clients need to be assured that when interpreters engage in their day to day social interaction, they will be complying with professional values. This is particularly important as interpreters work in languages where the communities are small, people are familiar to one another and their role as an interpreter is highly visible. Role modelling is an important aspect to ensure community confidence so that respect for the interpreter role and the integrity of the profession is maintained.

The Code of Ethics for interpreters and translators practicing in Australia was developed by the Australian Institute for Interpreters and Translators (AUSIT) and endorsed by NAATI as well as accepted by most major organizations, including the NSW Health, Health Care Interpreter Services. The Health Care Interpreters Code of Ethics is outlined in the NSW Health Policy Document 2006_053, *Standard Procedures for Working with Health Care Interpreters (Appendix 1).* This document describes the roles and functions of the HCIS, situations in which interpreters must be used, what to do if an interpreter is not available and the responsibilities of health care providers when using interpreting services.

Whilst many definitions of interpreting have been postulated, it is widely accepted that the basic role of the interpreter is to facilitate communication between two parties who do not share a common language as accurately as possible without adding or omitting information. The act of dialogue interpreting, however, is not this simplistic. Spoken and Sign language research conducted over the past two decades across a variety of settings has recognized the interpreter as being an active participant (Berk-Seligson, 1990; Moody, 1994; Roy, 1996, 2000; Kaufert & Putsch, 1997; Wadensjö, 1998; Cambridge, 1999; Nishizaka, 1999; Pöchhacker & Kadric, 1999; Mason, 1999; Metzger, 1999a, 2004; Davidson, 2000; Angelelli, 2003, 2004; Bot, 2003; Meyer

et al., 2003; Brennan & Brown, 2004), thus placing linguistic and non-linguistic demands on the interpreter which necessitates controls, specific coping strategies or techniques to be employed in order to adhere to ethical practice (Napier, 2002).

Dean & Pollard (2001) propose that the types of demands fall into the following categories: linguistic; environmental; interpersonal; and intrapersonal, each with their own demand sources (see table 1). Since interpreting is contextual in nature, only general examples of sources are illustrated.

Due to the complex interactional nature of dialogue interpreting, practitioners will often find themselves confronted with ethical dilemmas in-situ that necessitate referring to the code to guide and protect them in their practice. Employing this type of approach to practice, interpreters are potentially reducing the many challenges and dilemmas that arise during an interpreting event. Accordingly, adherence to professional ethics would be classified as an overarching demand source of each and every assignment that a practitioner undertakes.

Table 1 Types of demands and examples of sources in interpreting

Demands	**Sources**
Linguistic	Psycholinguistic influences: • Memory • Information processing • Metalinguistic awareness • Time-lag • Turn-taking cues • Concentration • Active listening Sociolinguistic influences: • Politeness norms • Cooperative principles of conversation • Clarification • Interruption & clarification • Overlap

	Interpreter's language reception • Audibility • Visibility (Auslan) • Fluency • Modes of communication (Auslan) • Spatial mapping (Auslan) • Constructed action & dialogue (Auslan) • Visual metaphors (Auslan) • Ambiguity of signs and concepts (Auslan) Interpreter's language production • Fluency • Intonation • Signing space (Auslan) • Vocabulary • Syntax • Grammar • Cohesiveness • Style
Environmental	Setting Positioning
Interpersonal	Power & authority dynamics Majority verses minority culture Professional obligation • Educating participants about role & ethical boundaries
Intrapersonal	Dynamic nature & intensity of assignment Physiological responses & reactions • Anxiousness/ Nervousness/Tiredness Doubts & questions about performance

(Adapted from Dean & Pollard, 2001)

3.0 The study

The rationale underlying this study was to acquire statistical information from relevant stakeholders to assist the HCIS to better understand the knowledge levels of those working with

interpreters, through which we may gain a better understanding of realistic or unrealistic expectations placed on interpreters. Through this feedback we will extract qualitative and quantitative data pertaining to the knowledge of the code the interpreter holds and whether this knowledge is effectively demonstrated within the interpreting session. If all parties do not share the same knowledge base then this not only can, but will inevitably become a barrier to effective communication.

3.1 Rationale

A questionnaire was designed and used as the instrument to measure the results for this study. A letter briefly outlining the research rationale *(Appendix 2)* and questionnaire were sent to all participants, excluding the deaf clients where a process of consultation was employed.

Similar to many minority language groups within society, deaf people congregate at social functions on a regular basis for communication purposes. A member of the research team attended a function with the purpose of obtaining data for this study.

Unlike many spoken languages, Auslan does not have a written form. The resultant value is varying degrees of English literacy levels found within deaf communities. It was recognized that in order to obtain qualitative and quantitative results, the questionnaire needed to be accessible to this group of people. Accordingly, it was decided a hybrid approach was the most appropriate and the deaf clients were given the option of either responding to a written English questionnaire *(Appendix 3)* or a face-to-face interview process conducted in Auslan, thus adopting the method used in a previous study with deaf people (Bonser & Burns, 1998).

One questionnaire was designed for practicing health care interpreters, with 7 questions *(Appendix 4).* Seventy-seven health care interpreters, both staff and sessional interpreters employed by HNEH were asked to respond to the questionnaire. The other questionnaire, which

contained 3 questions, was disseminated to 50 randomly selected health professionals employed by HNEH *(Appendix 5).* The exact 3 questions were translated into the relevant languages and circulated to 130 NESB and deaf clients, the majority of these utilizing the HCIS in the preceding 6 months in the public health system *(Appendix 6).* The language groups of the NESB clients included Bosnian/ Croatian/ Serbian, Chinese, Italian, and Auslan. The basis for selection for these specific language groups relate to the numerous occasions of interpreter service provided by the HNEH HCIS. Data was collated and the questionnaire responses were reclassified into AUSIT's and ethical principles: Professional Conduct, Confidentiality, Competence, Impartiality, Accuracy, Employment, Professional Development and Professional Solidarity.

4.0 Findings

The response rate was small, with only 38% of interpreters, 36% of health professionals and 34% of NESB and deaf clients responding to the questionnaire. Below is a report of the responses to each of the questions. Segments in italics are some examples of verbatim quotes from respondents (r).

4.1 Interpreter Responses

Question 1: How long have you worked as an interpreter?

Average period of working as an interpreter for MHU HNEH was 16 years. This ranged from 3 weeks to 30 years.

Question 2: What is the role of the interpreter?

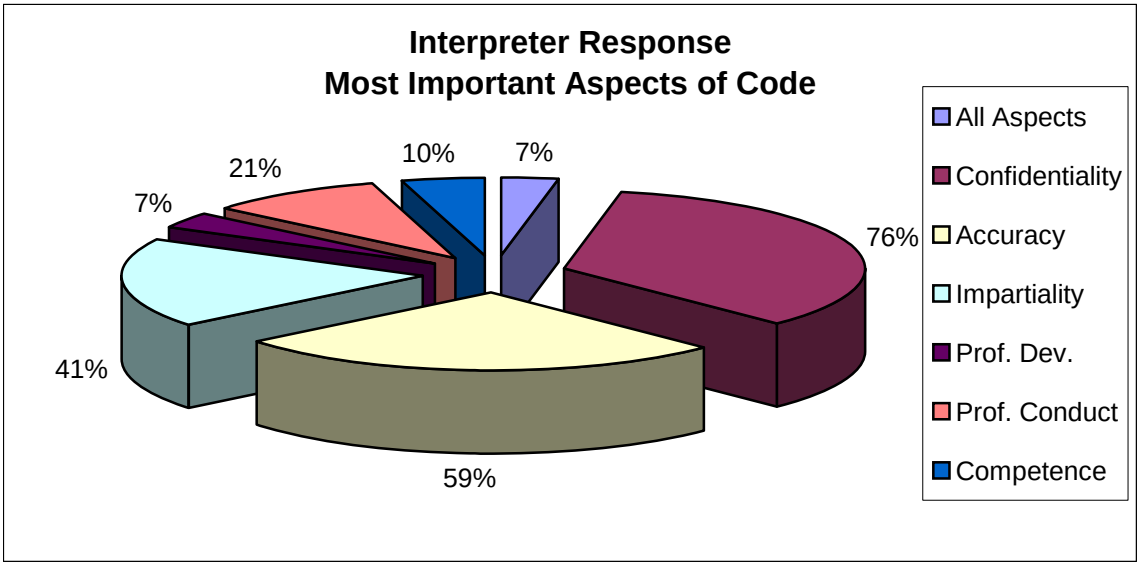
Words used to describe the role of the interpreter included to transfer, provide, relay or enable effective communication, with 34% describing the role as facilitating communication.

Questions 3 and 4: Do you introduce yourself to the NESB/ deaf client / Health Professional before you start interpreting? If so, how?

The purpose of this question was to elicit information in relation to whether role and ethics were included as a preface to the interpreting event. All of the interpreters responded that they stated their name and position. Of these, 41% introduced the agency they were working with, whilst only 18% referred to role and / or ethics in the introduction.

Question 5: What do you consider to be the most important aspects of the Code?

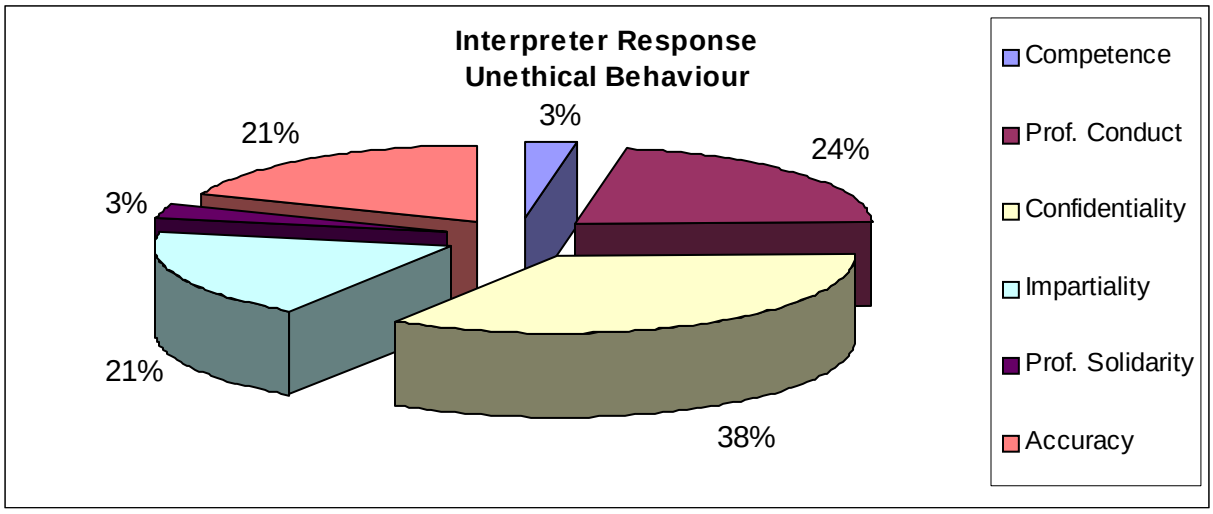
Interpreters were not limited to how many tenets they could mention. Seven percent, that is 2 interpreters out of 29, said that all of the 8 principles of the code were of equal importance, with one reason being *because they are essential to a professional performance (r5).* Seventy-six percent of all interpreters felt that maintaining Confidentiality was the most important tenet, whilst Accuracy was listed 17 times and 12 interpreters felt that Impartiality was also important. Twenty-one percent, that is 6 respondents referred to Professional Conduct as being most important. A comment by one interpreter summarizes this tenet by saying that *interpreting is a profession, therefore we should act accordingly, i.e., clean and tidy appearance, manner should be polite yet assertive (without intimidation) and respectful, always disclose any potential conflict of interest such as family or friend, always interpret any dialogue directed at you so as not to exclude any participant in the event and should refrain from self-soliciting/promoting by diarising any future assignments (r6).* Competence was listed 3 times whilst continuing one's Professional Development was only referred to twice.



Graph1. What do you consider to be the most important aspects of the Code?

Question 6: What do you consider to be unethical behaviour by an interpreter?

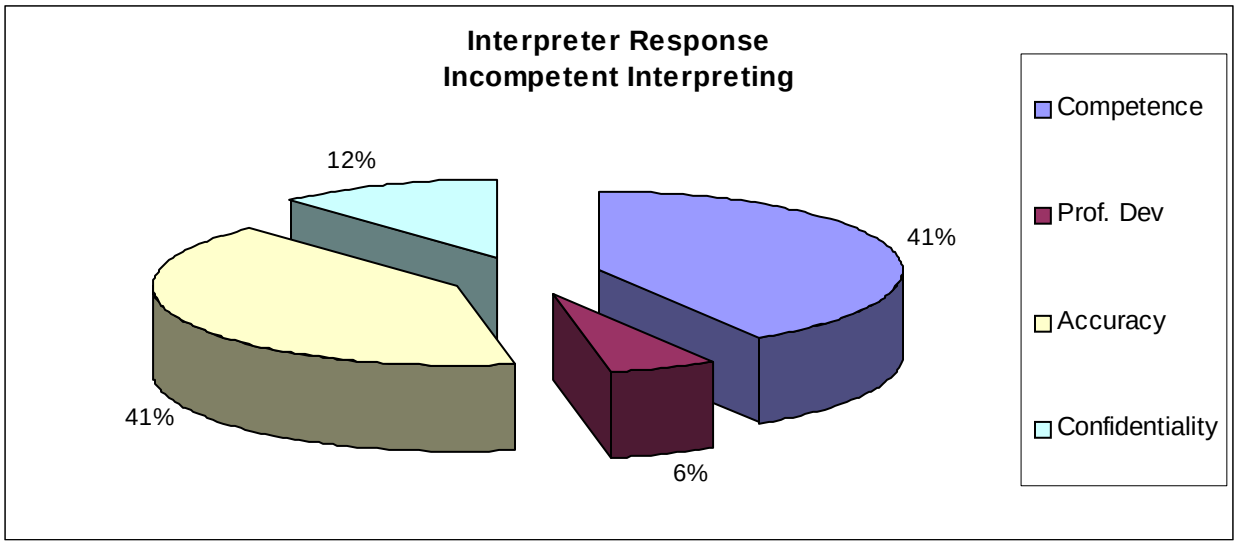
Interpreters were asked to give one example of what would constitute unethical behaviour by an interpreter. Thirty-eight percent believed that breaching confidentiality would constitute unethical behaviour. Twenty-four percent of all interpreters referred to issues which would be classified under the tenet of Professional Conduct such as, *not declining an assignment for which there are valid reasons for that assignment to be rejected (r1), not disclosing relationship with client if there is one, requesting that the health professional specifically book you for the next appointment (r5), giving private phone number to clients and health professionals and prying into clients private life, i.e., asking questions which have no relevance to the appointment (r10).* Issues relating to Accuracy and Impartiality rated equal third at 21% of all respondents. Comments included g*iving unsolicited advice (r10), withholding information (r16), adding and omitting information, pretending to understand a word or concept and adding one's own opinion, feelings or personal information (r6).*



Graph 2: What do you consider to be unethical behaviour by an interpreter?

Question 7: What do you consider to be incompetent interpreting by an interpreter?

Issues relating to Competence and Accuracy were believed to be issues which would constitute incompetent interpreting. Some examples include: *Answering on behalf of clients, missing or substituting part of the message (r6) , only interpreting information you feel necessary to interpret, not understanding the subject matter and lack of knowledge of medical terminology (r16),* and *to be incompetent in one language or both (r1).*



Graph 3: What do you consider to be incompetent interpreting by an interpreter?

NESB/ Deaf Clients

Question 1: Are you aware that interpreters are professionals and have a Code of Ethics that they need to follow and if so, what aspects of this Code are you aware of?

Ninety-one percent of clients answered yes to the first part of the question and described features such as confidentiality, appearance, accreditation, professional conduct, accuracy, punctuality and competence as those that they were aware of. Nine percent of respondents simply answered 'No'.

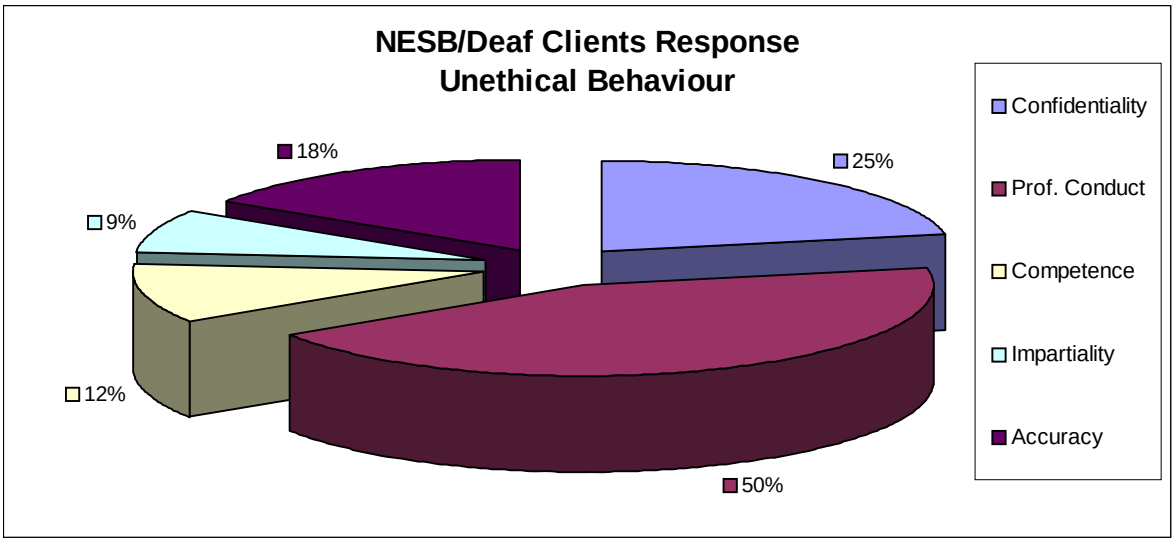
Question 2: What would you consider unethical behaviour by an interpreter?

Fifty percent of the respondents believed that not adhering to principles of professional conduct would constitute unethical behaviour. Some of the responses are outlined below: *Bad attitude, lack of interest (r2), less than personal professional presentation, interpreter actively canvassing for future work, using the booked situation to 'gossip' or 'catch up', interpreter not prepared for the booked assignment, (r4), telling me about themselves (r5), arriving late or not*

at all, touting for service (r11), oppressing deaf people by speaking on their behalf (r17), feeling sorry for me (r9), making decisions without client's knowledge i.e., "don't worry, you don't need to know" (r23), being too friendly with me, bad manners i.e., answering phone while interpreting (r44), and *when the interpreter wants to dominate the conversation and even change the topic (r30).*

Confidentiality rated second at 25% with these clients being worried about their personal and private information *easily and thoughtlessly being passed on to others (r31).* Other comments included, *gossiping about other deaf people, asking me about other people in the community (r3), talking to others about me, talking to me about other interpreters (r7),* and *telling me about themselves (r5).*

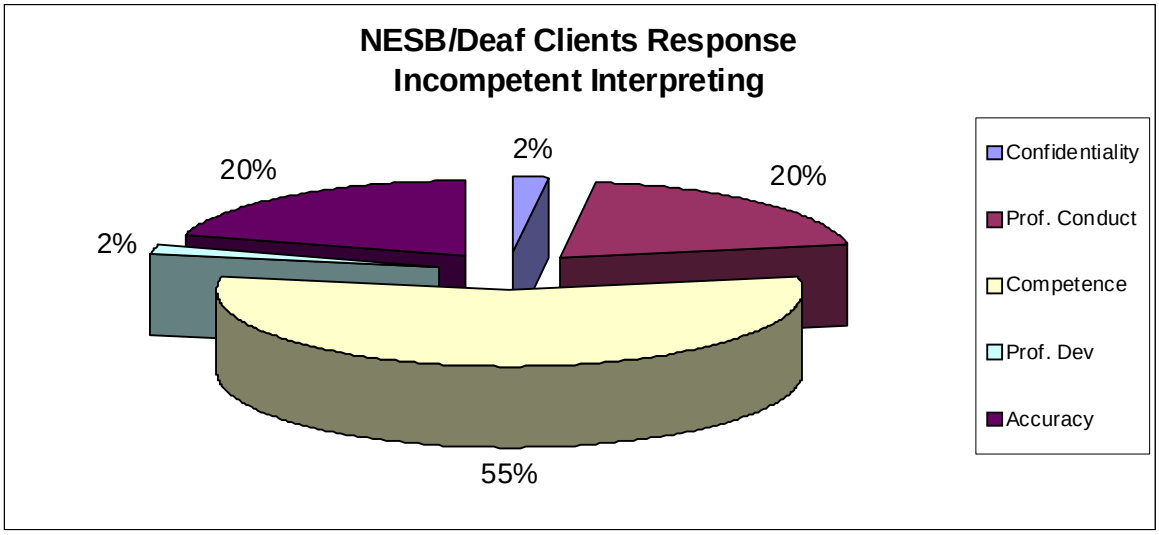
Eighteen percent of clients mentioned issues relating to accuracy as being unethical. Some of the comments were, *rubbing nose, using wrong signs (r24), can't explain words (r25), not full Auslan (r27), summarizing (r28),* and *not being educated and not knowing the medical terms used and knowing the subject matter (r41).*



Graph 4: What would you consider unethical behaviour by an interpreter?

Question 3: What would you consider to be incompetent interpreting?

Fifty-five percent of clients saw competence as a major issue. *Using unfamiliar signs, rubbing of the nose, clear fingerspelling (r10), not keeping still (r17), not being fluent in both languages, unqualified/unregistered interpreters (r23), not knowing medical terminology, not understanding the subject matter and not changing long words (r2)* and *no lip movement (r6)* were some of the comments. Other remarks included, *when the interpreter adds his/her ideas and opinions when talking in the (patient-doctor) conversation (r30)* and *when the interpreter doesn't understand both languages well and misinterpreting what has been said (r25).*



Graph 5: What would you consider to be incompetent interpreting?

Health Professionals

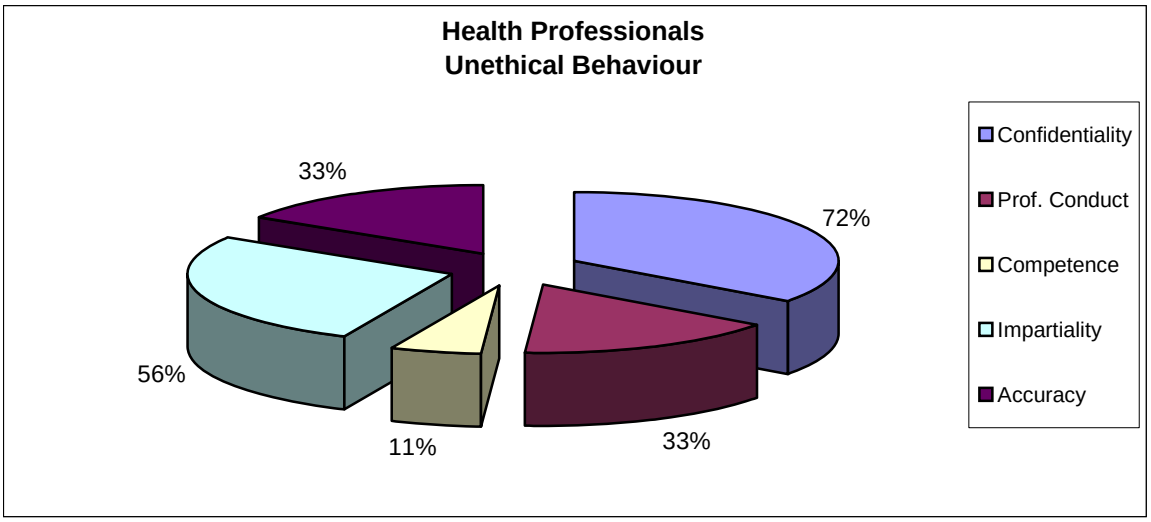
Question 1: Are you aware that interpreters are professionals and have a Code of Ethics that they need to follow and if so, what aspects of this Code are you aware of?

Thirty-three percent of health professionals responded that they did know that interpreters were professionals with a code of ethics and described confidentiality, impartiality, professional

conduct and conflict of interest as being part of the code. Another 33% said that 'Yes' they knew that interpreters were professionals but did not know or were not aware that they had a professional Code of Ethics. A further 11% said that they thought that the interpreter was a professional and assumed they would have some sort of code, presumably not unlike other professionals even though they had never seen a copy and 22% simply answered 'No'.

Question 2: What would you consider unethical behaviour by an interpreter?

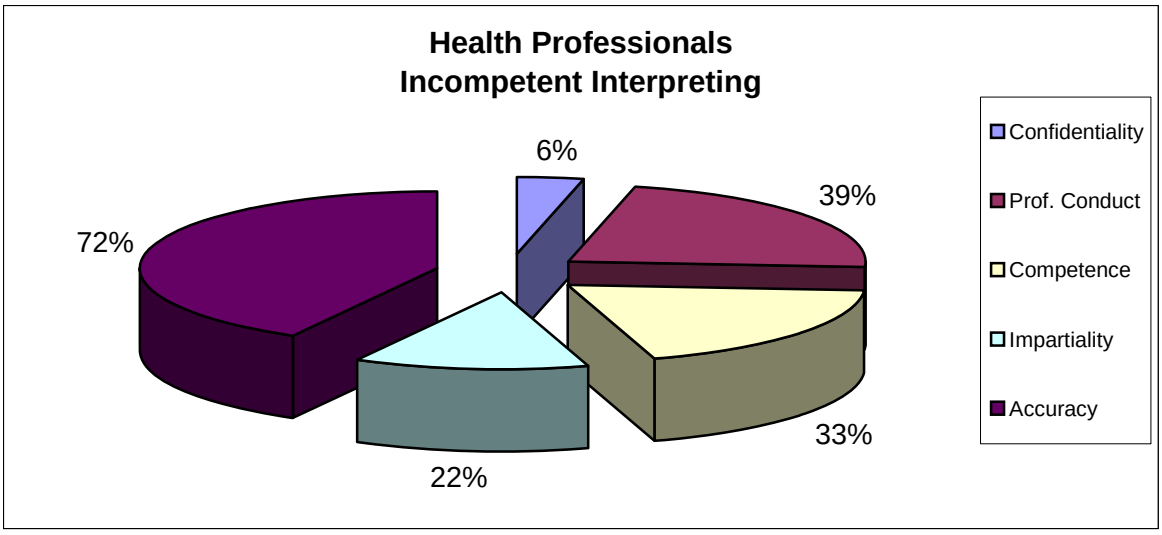
Breaches of confidentiality (72%) and impartiality (56%) are seen as a major concern of unethical behaviour. Examples of respondent answers include: *expressing disparaging thoughts about the patient (r1), sharing information to a third party without client's consent (r4), not interpreting accurately (r8), adding on comments that were not stated (r10), offering opinions (r11), not advising health professional of personal relationship with client (r12), being present for procedures when patient is anaesthetized (r13), adding or changing content (r14),* and *dishonesty, misconduct/ abuse towards a patient: verbal, physical, sexual (r17).*



Graph 6: What would you consider unethical behaviour by an interpreter?

Question 3: What would you consider to be incompetent interpreting?

Not interpreting accurately was seen as a major concern with 72% of health professionals believing or perceiving that interpreters were *paraphrasing, omitting and editing (r1).* Some believed that interpreters were not actually interpreting, instead they were *speaking for the patient (r7), blocking what was said (r10)* and that some interpreters were *continuing with interpreting when it becomes obvious that there are major dialectical problems(r1).* Other examples include *not attempting to clarify issues if the message is ambiguous (r4), Not disclosing own limitations as a professional (r4), becoming emotionally involved (r10),* and *providing more information than was asked to be delivered (r13).*



Graph 7: What would you consider to be incompetent interpreting?

If we summarise and compare the available data, 72% of Health Professionals viewed a breach of Confidentiality as constituting unethical behaviour compared to only 38% of Health Care Interpreters, whilst 50% of NESB and Deaf clients saw a breach of Professional Conduct as representing unethical behaviour.

Once again, a large majority (72%) of Health Professionals thought that breaching Accuracy was equivalent to incompetent interpreting compared to 41% of Health Care Interpreters. More than half of the surveyed NESB and deaf clients (55%) saw a lack of Competence as signifying incompetent interpreting.

The data collected may be considered subjective, as the sample sizes are small. Nonetheless, the responses have enabled the research team to elicit information which portrays the perceptions held by relevant stakeholders.

5.0 Discussion

Interpreting is like a juggling act. Interpreters have to analyse the meaning of a message and translate as accurately as possible choosing the right signs or words so that everybody understands and communicates well. Interpreting is also a balancing act, trying to meet the needs of various deaf clients, hearing clients, and paying clients in different situations (Napier, 2005). It is therefore, essential that all participants within the communication event understand the limitations of the interpreter's role.

The aim of this paper was to try to get a better idea of the key stakeholders' knowledge of the role of the health care interpreter and the interpreter's Code of Ethics, specifically what perceptions they held. The data obtained in this study indicates health care interpreters are knowledgeable of their role and what constitutes unethical behaviour and incompetent interpreting, with all of them describing their role working within the facilitation model of interpreting. Unlike previous studies into medical interpreting (Kaufert & Putsch, 1997; Cambridge, 1999; Davidson, 2000; Bot, 2003; Meyer et al., 2003; Angelelli 2004) none of the interpreters used words such as, 'to help', 'to support' or 'to advocate', in depicting their role.

Responses suggested that interpreters were knowledgeable of the Code of Ethics and were able to explain the importance of the tenets and how they relate to unethical behaviour and incompetent interpreting. However, the short fall seems to occur when interpreters introduce themselves and explain their role to the parties they are working with. Interpreting is an emerging profession (Scott Gibson, 1991) therefore, the function and ethical boundaries of practice are not widely known. Consequently, people will have "misconceptions and preconceived ideas about the nature and performance of the interpreter's work." potentially giving rise to unrealistic expectations of the interpreter (Gentile et al, 1996: 6.) As illustrated previously in table 1, an effective pro-active coping strategy to avoid confusion and lessen the occurrence of ethical dilemmas is to educate those they are working with, on how they will be working and what their limitations are. It was evident that this was not a priority for many interpreters as only 18% of all interpreters participating in this research referred to their role and the Code of Ethics in their introduction, despite the fact that the annotations to the principal of 'Professional Conduct' states "Interpreters and translators shall explain their role to those unaccustomed to working with them" (AUSIT, 1996). The data supports this notion showing only 11% of health professionals assumed that interpreters were professionals and assumed there would be some sort of code and a further 22% declared that they did not know that interpreters were professionals with a professional Code of Ethics.

Different perceptions of what was most important for interpreters, what would amount to unethical behaviour varied between confidentiality at 38%, professional conduct 24 % and both accuracy and impartiality scoring 21% compared with 72% of health professionals who were quite clear that confidentiality was the most important principle defining ethical behaviour. This is understandable as for most health professionals, a rights based approach is paramount,

confidentiality is regarded primarily as a means to an ends. It protects the health of the population and the individual within it by allowing them to come forward for medical care and treatment without fear of embarrassment and or other harm (O'Brien and Chantler, 2003). Fifty percent of NESB/ deaf clients stated that for them, violation of professional conduct would define ethical misbehaviour. This finding is also supported by Brough (2006: 29) who found that, **"**Participants most valued interpreters who were respectful, maintained their professional boundaries and were compassionate".

Incompetence and inaccurate interpreting were considered as major issues with 41% of interpreters and 55% of NESB/ deaf clients believing that not being competent within the profession was a concern and 72% of health professionals felt that not being able to interpret accurately would constitute incompetent interpreting. Hale (2004:239) describes accuracy "as portraying the intention of the original message in the target language, with the same illocutionary force, so that the listener of the interpreted message can perceive the message and its author in as similar a way as a listener of the source message would. Such a level of accuracy requires faithfulness of content and manner of speech".

It is interesting to note that even though both health professionals and interpreters agreed on which tenets were most important for both areas, the feelings seem to be much stronger for the health professionals than the interpreters. If we all agree that the role of the interpreter is to facilitate communication then we would also agree that by disempowering our clients, i.e., both parties, through not interpreting accurately, by not maintaining objectivity, breaching confidentiality and not maintaining our skills we could potentially become the barrier to effective communication. However, "What no code can do is anticipate all possible situations" (Tate & Turner, 2001: 53). On the other hand as Fritsh-Rudser (1988) pointed out "interpreters don't

have a problem with their ethics, they have a problem with their role" (cited in Roy, 1993: 134). This would be supported by responses received from NESB/ deaf clients where it was suggested that interpreters are *feeling sorry for me (r9), being too friendly with me (r44), gossiping about other deaf people, asking me about other people in the community (r3),* and *talking to others about me, talking to me about other interpreters (r9).* With responses such as these, one would have to question whether there might be some conflict or unawareness of the role itself. Moreover, these findings are clear indicators of unethical practice, reminding us of the importance of Professional Development where role and ethical issues can be discussed and debated so that reflection of ethical matters can aid to produce best practice. Furthermore, critical self-reflection and insight are a fundamental part of being a professional. Regular practice would allow one to explore their own professional and personal strengths and weaknesses and acquire a willingness to seek to learn and improve.

Furthermore, we must not forget that the Code of Ethics is a management tool for establishing and articulating the values, responsibilities, obligations and ethical ambitions of an organization and the way it functions. It provides guidance to employees on how to handle situations, which may pose a dilemma between alternative right courses of action, or when faced with pressure to consider right and wrong. It can only be effective and practically useful with committed dissemination, implementation, monitoring and embedding at all levels so that behaviour is influenced. This then brings the focus on the service provider and their responsibility as well.

In Australia, NAATI accredited interpreters are bound by a Code of Ethics; nonetheless it would be true to say that many workplaces that employ interpreters may not completely monitor their interpreters to ensure they abide by the appropriate code of practice, nor do many

employers have in place quality assurance measures to ensure interpreters are working to an appropriate standard that is acceptable to their service users (Napier, J., Bontempo, K., & Leneham, M., 2006). In a recent discussion paper, the Australian Association of the Deaf (AAD) questioned how does an agency monitor an interpreter's behaviour and compliance, as there is also no standard system for monitoring interpreters' ethics and no way to enforce the Code of Ethics since the majority of interpreters work alone most of the time (AAD, 2007).

The outcomes of this study have enabled the Health Care Interpreter Service (HCIS) to identify its own shortcomings as service provider and the responsibilities it has to its employees and the interpreting profession. How can we ensure that our employees are clear about their roles, accountabilities and deliverables to the organization and that they receive regular guidance and support? Sometimes we do not recognize the ethical dimensions involved or know where to turn to for help with resolving them. The question is: do we encourage wide active discussion in a safe, non-judgmental environment?

The NSW Health Care Interpreter Services today are more distributed than ever and are challenged to accurately measure and understand the talent in their broad and distinct organizations. Especially in organizations recently involved in merger or acquisition activity, the ability to make and support employees can be severely hampered by the lack of consistent and automated measurement processes. There is a greater emphasis on the HCIS to ensure Performance Management and Health is moving from a system where hospital and health services had separate approaches to complaints and clinical errors, to a system where uniform standards and processes have been introduced to make sure that the system learns from its mistakes and solutions are adopted system-wide.

The study suggests that interpreters have a great responsibility as professionals not only to understand, appreciate and value the code their profession has established but they also have a great responsibility to be able to demonstrate that knowledge in practice as well as educate all of those around them on their role and code so that there is no confusion. The responsibility is for all interpreters to behave in a uniform way. This will enable those working with them to have realistic expectations as well as see the profession for what it is, and that is, a Profession.

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